FOR IMMEDIATE RELEASE

East Central Human Rights Authority
Report of Findings
Heritage Healthcare
11-060-9004

The East Central Regional Human Rights Authority (HRA), a division of the Illinois Guardianship and Advocacy Commission, accepted for investigation the following allegations concerning behavioral health services at Heritage Healthcare located in Hutsonville, Illinois.

Complaints:

1. The facility failed to provide 24 hours of continuous supervision, support and therapeutic interventions.
2. The facility failed to provide case management services and discharge preparation.
3. The facility failed to provide crisis services.

If found substantiated, the allegations represent violations of the Nursing Home Care Act (210 ILCS 45 et seq.), and the Sheltered Care Facilities Code (77 Ill. Admin. Code 330 et seq.).

Heritage Healthcare is located in the village of Hutsonville, Illinois. Included in the grounds of Heritage are the shelter care facility and cottages for independent living. There are outdoor areas for the residents, as well as an indoor recreational space for residents to gather and visit. The surroundings are a rural wooded environment. The Department of Public Health categorizes Heritage Healthcare as a sheltered care facility. Per the DPH website: "A sheltered care facility provides personal assistance, supervision, oversight and a suitable activity program. Provisions are made for periodic medical supervision and other medical services as needed. Such facilities are for individuals who do not need nursing care, but do need the services listed above in meeting their needs."

COMPLAINT

Per the complaint, a veteran was forced to vacate the apartment he had been renting, as part of services received from Heritage Healthcare. He was discharged with no plan in place to address his mental and physical health needs. He was homeless for several months after being evicted from his apartment. A third party (another disability provider), had referred this veteran's placement for housing based on the veteran's disability. Heritage provided transportation to the Veteran's Administration (VA). The veteran was evicted from Heritage after he could not pay his rent due to the VA delaying his VA service connected benefits. VA benefits were delayed for about a month. He normally pays rent by the 3rd. On 4/10/10 he was sent an eviction notice.

Allegedly the apartment building at Heritage had already been condemned about a year before a fire.

FINDINGS

Site Visit

The HRA proceeded with the investigation having received written authorization to review the veteran's record. To pursue the matter, the HRA visited the facility where the administrator and staff were interviewed. Relevant practices and policies, and sections including the referral portion of the veteran's VA record, were reviewed. The HRA had also submitted a FOIA request to the local health department for records regarding the building and contacted the local volunteer fire department.

Staff explained that the type of services provided was sheltered care and the geographic area served was anywhere in the United States. There are 32 residents that are provided care at the facility, but not all of the shelter care residents are veterans and there is no contract with the Veteran's Administration. When asked about the typical referral process with the VA, the response was the VA determines what is needed for each individual. There is an admission packet, TB test, and a signed contract for sheltered care; residents receive a copy of their rights. Referrals are made from numerous Veterans' Administration offices throughout the state and the country. The VA referral determines which individuals would be admitted to sheltered care services and who would rent semi-independent cottages or apartments.

The HRA presented evidence to the provider which included a referral from a VA social worker that the patient needed to be admitted on 11/1/07 specifically for residential care (supervised living.) The referral states that his goals included in this referral were to improve compliance with medications and treatments, reduce hospitalizations and/ or ER visits, supportive living/supervision, and behavior stabilization. The HRA inquired how these goals could be attained when he is a renter. The response from the administrator was that sometimes all it takes is providing the opportunity to provide shelter, food, and some supports. He would have a cottage to live in which included rent, utilities, furniture and three meals every day. He could also ride the transport owned by the shelter care facility which provided daily trips to the VA for any medical needs. He would pay $750.00 per month. The veteran was in the VA homeless program. From the referral of the social worker he was referred to the cottages for independent living. It was further explained to the HRA that the individual may not have access to a sheltered care facility due to certain admission requirements.

The administrator explained that the veteran was never admitted to the shelter care facility, but in total independent living arrangement. His trips to the VA were made on the VFW minivan. He supervised his own medicine. The VA social worker visited him in his apartment downtown. There was no government subsidy provided for this housing. There was also no lease. Per the administrator on 10/2008 the individual chose to move to the apartments owned by the provider. This apartment was in a different part of town and was in an older building. The rent was $400.00 per month and included all utilities. The veteran's social worker from the VA had visited him at the apartment several times. The veteran lived there for two years. He was

evicted because a fire in the building made it an unsafe place for him to live. He was offered a place back in cottages and meals and he refused the opportunity.

The provider stated that she had previously held his place when he did not get a check from the VA for three months, and provided meals at the sheltered care, so he would not go hungry. She personally provided transportation for the individual when he was hurt while living in the apartment. Reportedly, the veteran stated he did not want to socialize or have the stigma of being a veteran receiving services. He would ride the VFW van instead of the Heritage bus. Staff shared that the individual was going to move before the fire. The administrator had helped him fill out the HUD paperwork. Staff claimed the individual was angry after the fire and wanted the firemen to pay for water damage to his valuables in his apartment. When he received notice that the building had been condemned and everyone had to move, the individual became angry. He refused to move even though he was offered an opportunity to move back to one of the cottages. Per the administrator the fact that he was unable to pay his rent did not have any affect on him being forced to move and not be transferred somewhere else. The administrator had heard reports that the individual said he was going to take her down. When the veteran refused to move, the administrator hired a lawyer to evict him. She did not do discharge planning because he was not in a sheltered care facility and there were no discharge requirements. She claimed before hiring an attorney that she offered him a chance to move back to the cottages.

The administrator stated that she uses the same contact information for her sheltered care facility, the cottages, and her rental business simply to save money. A savings she passes on to those who use her facilities. When the HRA asked her if she would consider running her private rental business out of a different office with different contact numbers, her response was that both are small businesses and she could not afford to provide services to community if she had to set up two separate offices.

The HRA toured the sheltered care facility. Rights and third party contact information were posted. Several individuals stated that they liked living in the facility. Private rooms were decorated by each individual according to their preference. There was a large room that had tables and places to sit where individuals were playing games, cards and were visiting. When individuals were asked if they liked the facility the answer was yes. The HRA asked some of the residents about the care and food provided. The responses were all very positive. The facility smelled clean and residents seemed to be very comfortable in the facility as they participated in various activities.

Next the HRA was given a tour of all of the cottages. All of the cottages were accessible to individuals with disabilities. They really did not appear any different than most 3-4 bedroom ranch homes. Anyone who lived at the cottages was able to come to the sheltered care facility for meals. The cottages had full kitchens, bathrooms and each cottage was comfortably furnished. Some had pianos for playing music. The HRA also observed one of the transport vehicles that was used for trips back and forth to the VA. The HRA also noticed that the grounds of this facility and the cottages were by the woods. The grounds had flowers and those who lived in the cottages and the sheltered care facility could observe wildlife and nature. There were also picnic tables under the trees.

Policy Reviews

The HRA requested a copy of any agreement between the provider and the individual. There was never a contract between the two parties. The provider only used contracts at the sheltered care facility. The HRA reviewed a blank contract. It was in large print. It explained in detail what the facility would provide to the resident receiving services and what it would not. It also explained that a resident and/or guardian would receive a copy of their rights and responsibilities which was attached to the contract. There was a place for the resident to sign that they received a copy of their rights. It addressed that before a person is admitted to a facility, or at the expiration of the previous contract, or when the source of payment for the resident's care changes from private to public funds or from public to private funds, a written contract shall be executed between the facility and the individual.

The HRA reviewed the policy for the admission to Heritage Healthcare. Based on these policies, the individual would not have had access to the sheltered care facility due to certain admission requirements. There was a separate policy for the cottages and that would allow the individual to live there.

House rules for cottages required all residents to be able to administer their own medications, come for meals on time, and make their beds daily. Smokers were required to only smoke at the kitchen table, never anywhere else in the house. Each individual was expected to maintain his own personal hygiene. No alcohol or drugs were permitted on the premises. If someone would bring these items into a cottage they would be required to leave immediately. Respect for other individuals in the cottages was expected in regards to privacy, and noise levels. No overnight guests were allowed. Individuals from the cottages, could visit at the sheltered care facility, but had to leave by 8:00 pm and not return until 6:30 am. House residents would have all three meals at the sheltered care facility and stay for snacks then return to the cottages by 8:00 pm. If they left the house they had to sign out when they would leave, report where they were going, and when they would return. Staff could ask any individual who lives in the cottages, to leave the shelter care facility at any time and return to the cottage. It also listed a way that a person could bring up a concern or a complaint. It stated that if an individual was unable to live at the cottage, they would be evaluated and a decision would be made as to whether they could remain in the cottages. If they could not follow the cottage rules they would be asked to enter the main facility to live. It also stated that residents in houses may not come back to the Heritage Shelter care until 6:30 am, unless there is an emergency or they need to do Accu checks for diabetes.

Record Reviews

There were no records for the individual at the sheltered care facility since he was not considered a resident of the sheltered care facility. The records that the HRA reviewed are from the veteran's record from the VA and the Crawford County Health Department as well as the Crawford County Newspaper, a report on the fire from the local volunteer fire department, and a letter from the facility's attorney to the veteran.

On 10/31/07 VA medical records of the individual show that the licensed clinical social worker (LCSW) documented that the arrangements have been made for the veteran to be placed

at Heritage Shelter Care. This was due to inability to sustain independent placement. The individual was currently homeless. He struggled with preparing meals and managing finances. He could only return to the homeless shelter for three days. Admission date is 11/1/07. The placement was coordinated by the LCSW. The referral was to residential care (supervised living). The goals of the care were to improve compliance with medications and treatments, reduce hospitalizations/and or ER visits, supportive living/supervision, and behavior stabilization. The estimated duration of services was indefinite. Under other comments the consultation sheet stated: "The veteran can benefit from a structured environment and is referred to Heritage Shelter Care Home, 207 Wood Lane, Hutsonville, IL for placement on 11-1-07. He will enter the semi-independent living houses and will pay $750.00 per month. Arrangements will be made for the veteran's cost of care via his payee."

On the same date the next sections of the VA medical records document that a consultation was completed by the registered nurse regarding the veteran's care. Under the skilled care section the only treatment he required was the use of a continuous positive airway pressure (CPAP) machine. He needed no assistance with basic activities of daily living, incontinence, and skin problems. There were no behaviors in the last seven days according to the section on patient behaviors and symptoms. Under cognitive status the patient made decisions with difficulty or decisions were poor. The veteran himself had indicated he had difficulty handling money and making decisions. He indicated that people easily take advantage of him. It was documented that in the last 7 days, the patient's expression of information was understood, even if he/she had difficulty in finding words or finishing thoughts. In the last 90 days, the patient became so agitated or disoriented that his safety was endangered or he required protection by others as a result. The prognosis section documents that the patient did not have a flare-up of a recurrent or chronic health problem. The staff that provide direct care think the patient is capable of increased independence. He is fully weight bearing. Under the diet section the veteran was on a low cal diet for morbid obesity. He is a type II diabetic. There is a recommendation again for a structured living arrangement and assistance with management of financial concerns. There is a need for monitoring of health concerns of hypertension, obesity and blood sugars. The veteran also has schizophrenia.

October 2008 was the approximate date provided for the veteran to be moved to his own apartment in a building owned by the same administrator in a different area of town away from the sheltered care facility and the cottages that were next door to it.

On 03/25/2010 the Crawford County Health Department per request of the administrator/landlord, had inspected the building that the veteran lived in. It is documented that the building is a potential health and safety concern. The east wall of the building had been collapsing and had separated from the soffit which allows an opening for animals to find harborage. The soffit and the roof appeared rotted. The upper story windows on the collapsing wall had broken glass which could fall out to the ground below. It was recommended that a building contractor or structural engineer be contacted to evaluate the building.

On 03/29/2010 VA mental health telephone encounter notes document that the veteran called very upset about the VA taking his whole check to pay for a VA pharmacy bill. The LCSW documented that he would review the letters sent to the veteran at his first opportunity.

According to a post dated check written 04-03-10 repair work was completed in the apartment to accommodate his specific needs.

On 4/2/10 there was a fire caused by some of the administrator's employees burning trash next to the building. Allegedly the veteran's property was damaged and his home was unsafe due to smoke and water damage.

On 04/12/2010 VA mental health telephone encounter notes document that the veteran stated the administrator had given him 30 days to move and that there had been a fire and the apartment was damaged. His possessions were either damaged or stolen because the apartment was not secured after the fire. He had a ceiling tile fall on his foot and had to go to the emergency room. The LCSW asked what he could do to help, the veteran asked him to write a letter to let the administrator know that his check was coming late and it was not his fault that he did not have the money needed to pay the rent. It was documented that the veteran had experienced multiple problems with money and bills, and he has endured several unexpected crises during the past several weeks. The veteran's behavior did not include acts of self-destruction or irrationality. The social worker verified that the veteran did complete the request to waive liability to pay money owed to the VA. The veteran would receive the money held back from him, after as much as 90 days. The social worker drafted a letter explaining that the veteran's check had been delayed. The veteran expected the check to come timely. It could be up to 90 days before the check would be released.

On 4/14/10 the veteran was issued a letter of eviction from the administrator's attorney. Enclosed with it was the draft complaint that would be filed if the veteran does not remove himself and his belongings within 7 days. The complaint states in section 4.: "That the Defendant has failed to abide by the terms of the lease and the landlord no longer wishes to rent to Defendant who has been given notice and continues to be illegally in the premises as a hold over tenant."

On 4/16/10 the local newspaper reported a meeting of the village board. The apartment building that the veteran had lived in was discussed as well as the structural integrity that appeared to be failing and the administrator/landlord's plans to demolish the buildings. These buildings were over a hundred years old and were considered an historic landmark.

On 5/3/10 the same local newspaper reported that demolition is planned for the building.

On 5/04/10 VA social work notes document the LCSW visited the sheltered care facility and was informed by the administrator that the veteran had left the care management provided by Heritage staff. The veteran now lives with friends in a nearby town.

On 6/28/10 VA social work notes state that according to the veteran, he had been given seven days to vacate his apartment that he had been renting as part of services received from Heritage Sheltered care. According to the veteran he had been discharged with no particular plan in place to address his mental and physical health needs.

On 7/1/10 the Crawford County Health Department, per request of the administrator/landlord, had inspected the same building. It was documented that the building is a potential health and safety concern. The building has fallen in and there were piles of bricks, boards and construction rubble. Part of the building was still attached to another building. There was a concern of loose bricks that could fall on persons using the other building. Demolition had started but was not fully finished.

CONCLUSIONS

1. The facility failed to provide 24 hours of continuous supervision, support and therapeutic interventions.
2. The facility failed to provide case management services and discharge preparation.
3. The facility failed to provide crisis services.

Pursuant to the Illinois Nursing Home Care Act, Chapter 210. 45/1-124.: "Sheltered care means maintenance and personal care." This individual was never admitted to the shelter care facility so he was not entitled to the maintenance and personal care of a sheltered care facility. When he did live next door in a cottage next to the facility, he may not have known that he did not have the protection of those who were admitted to the facility. His meals were provided and he had free transportation five days a week to the Veterans Administration.

His LCSW knew that he would be living in the cottages and referred to them as semi-independent living. The cottages were not the sheltered care facility. This sheltered care facility could not admit this individual because he may not have access to a sheltered care facility due to certain admission requirements.

The veteran moved from the cottages to the rental property in 2008 that was in a different part of that town and had lived there for over a year and a half which was his right. There was no signed contract between the provider and veteran for the cottages or the apartments.

The confusion was that the owner runs three businesses out of Heritage Healthcare shelter home. When the referral was made to Heritage Healthcare, there was no clarification to the recipient of services that if he rented an apartment or a place in the cottage, he could not expect the same services and/or protections as someone living in the sheltered care facility. This individual exercised his right in choosing to live where he wanted. In exercising this right, he assumed the same risks as anyone else that rents property, but considering his disability he may not have fully grasped the consequences of that risk.

The veteran seemed to have been functioning quite well in this environment until the VA garnished his entire service connected disability check. He also paid for enhancements to the apartment that he was forced to leave that same month. A fire in the apartment next to him destroyed the veteran's apartment with smoke and water damage. The fire was caused by his landlord's staff burning trash outside of the building and the building catching on fire. The veteran was notified that he was being evicted with 7 days to move. His building was no longer safe and had to be demolished. He lost his home, his personal belongings, and his entire check

for that month. There was no evidence that anyone explained to the veteran when he left the VA to move to the cottages and then to his own apartment that he would have no support system and he was really on his own.

The provider of all three properties claimed the veteran had the option to stay at the cottages since he had lost his apartment and claimed that meals at the sheltered care facility were provided during the times the VA had garnished his whole check. The complaint had alleged that the veteran was homeless with nowhere to go and had lost his personal belongings either to the fire or being forced to move. There was no documentation to support either the complaint or the administrator in regards to the ability of the veteran to return to the cottages. The HRA could verify that the apartment building was failing and from the evidence that the veteran would not have been safe living there. Based on the evidence that the veteran never lived in the shelter care facility, the following rights violations **are not substantiated:**

1. **The facility failed to provide 24 hours of continuous supervision, support and therapeutic interventions.**
2. **The facility failed to provide case management services and discharge preparation.**
3. **The facility failed to provide crisis services.**

The HRA does make the following suggestions:

1. Since Heritage Healthcare receives referrals from other healthcare providers for services to people with disabilities, there should be a policy in place to identify and document support contacts with the individual's or guardian's consent. This should include any individual that is referred to Heritage Healthcare for any service, cottage, apartment etc. That way there is a support system in place for that individual with a disability even if they are considered to be living totally independent from the facility.

2. Clarify to referring providers, the individual, the guardian and any resident representatives what services will or will not be provided. This individual was referred for "semi-independent living" but remained in "independent living." He was also referred for compliance with medications and treatments, supportive living/supervision, and behavior stabilization. That way the referring provider will know that this person is really on their own without any supports such as in this case. Social workers would know there would not be the safeguards of the Sheltered Care Facilities Code and persons referred to the cottages or rental properties would know that they are strictly renting.

3. There should be clear cut boundaries between the variations of businesses provided by the administrator to avoid future conflicts. If separate offices are not affordable then consider separate phone numbers, so that individuals with disabilities, seeking services will clearly know that the shelter care facility is one business, the cottages and rental businesses are another. This eliminates the expectation of the services of a shelter care facility for those who are only renting.

4. As far as the cottages and rental properties, the HRA strongly suggests that a rental agreement be completed that specifies exactly what is provided and what is not. This is

especially true when referrals come from other service providers asking that individuals with disabilities be placed in semi independent living. Per the administrator of Heritage Healthcare, the cottages and rentals are for total independent living outside of the shelter care facility. A contract would clarify the details needed for a social worker or an individual and/or guardian to make an informed decision.

5. The HRA suggests that when an individual moves from the sheltered care to the cottages or the cottages to the rental properties that there is a paper trail. Since Heritage serves people with disabilities in all three properties, this could be a process to inform the individual they are no longer receiving services from a service provider. An individual would know that as a renter their personal property is not protected and would not be replaced if it was lost, stolen or damaged. Consider including a reminder that they may need renter's insurance. If this individual had renter's insurance he could have recovered his losses.

The HRA does recognize that there has been much effort by this provider to keep costs down and make all of the businesses affordable to the people the provider serves. The rent for both the cottages and the apartment was very reasonable in the current market. Sharing a home with other individuals that provides meals and transportation to VA seemed to have worked for many. It also allows more freedom and independence for an individual who otherwise might have to live in a more restricted environment or no home at all.

The HRA acknowledges the full cooperation of Heritage Healthcare during the course of the investigation. This case was transferred from the Egyptian to the East Central region. The distance to travel for the East Central region was much closer in proximity to the provider and would allow for a more efficient investigation.